Michigan Department of Consumer & Industry Services
Bureau of Health Services
OHS-0206 (4/03)

File #_____

TREATMENT DATA FORM

NAME OF PATIENT:

_____

Date of Birth: _____ **Social Security Number:** _____

NAME, ADDRESS AND PHONE NUMBER OF DOCTOR(S) AND/OR HOSPITAL(S) PROVIDING TREATMENT FOR THE SAME CONDITION STATED IN COMPLAINT:

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

*****

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

*****

FULLNAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

*****

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

*****

FULL NAME: _____ **Dates of Treatment:**

ADDRESS: _____ **Beginning:** _____

CITY/STATE/ZIP: _____ **Ending:** _____

TELEPHONE: ( )

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Completion: Voluntary Penalty: None

Authority: P.A. 368 of 1978, as amended